RECTO-VAGINAL

AND

RECTO-LABIAL FISTULA,

A NEW METHOD OF OPERATING FOR.

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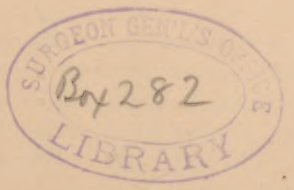

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In the August number of the *New York Medical Times*, for 1855, I published two cases of Recto-Vaginal and Labial Fistula, cured by a new operation for this disease. As I have since then had a more extensive experience in cases of this nature, I desire to confirm my limited experience at that time, after an interval of 22 years, when my first case was operated on and 12 years since I first published my cases. In presenting the subject to the New York State Medical Society, I ask the attention of its members to a simple and as successful an operation as could be devised for the benefit of females suffering from this loathsome and disgusting affection, inducing them to abstain from society as a general rule.

Since my first publication I have operated on more than 40 cases. Out of this number there have been but three or four that were not *cured*. In these cases after the closure of the internal orifice, the adhesions have given away by the patient rising too soon or straining at stool. These three cases resulted from syphilis, and where there was a syphilitic affection or syphilitic stricture of the rectum. During the last three months five cases have been operated on; four at the Charity Hospital and one in private practice. Two of the cases in the Charity Hospital were double fistulas.

Nature of the Cases.—The class of cases are those which are the result of abscess, springing from various causes, occurring in the cellular tissue in the perineal space between the fourchette and anus; or in the labia majora or minora; or from Bartholinis' gland; and sometimes from a chancre or chancroid.

The fistula may be direct or lateral with a long sinus. The external orifice being sometimes as high up as midway in the labia minora, then passing down to the perineal space and traveling up along the rectum laterally and opening either laterally or posteriorly into the rectum from two to three inches from the anus. In these cases the sinus or fistula will be from three to five inches in length. Sometimes the fistula is double, one

on each side. The external openings having only a space of one-fourth to one-half of an inch apart, and terminate in one opening or having separate openings in the rectum. When the fistula is double, the internal opening or orifice is just above the internal sphincter ani. Eight out of ten cases have existed on the left side.

Character of the Fistulæ.—They have small orifices or openings, both external and internal, sufficiently large to admit the ordinary silver probe; occasionally they may be as large as a split pea, and at other times so small as only to permit the smallest probe, and frequently are entirely overlooked. In these cases a valvular like opening exists; it may be covered by a duplicature of the mucous membrane of the labia or vagina. In one of the cases, when the external opening was the size of a split pea, the operation had been performed by an eminent surgeon,for closure by suture, but failed. I have noticed that operations of this kind have in other cases not only failed but enlarged the openings and made the fistula much worse, as the sphincter ani was not divided. By this simple operation the fistula was closed in two to three weeks. This winter, after an interval of three years, I had the pleasure of seeing my patient, and she had remained perfectly well ever since. The length of time some of these cases have existed varied from a few months to three or four years.

The character of the fistulæ, it must be understood, is not of that class that results by sloughing from inflammation, or from tedious labors or obstetrical instruments. In fistulæ of that nature the operation is useless. I do not deem it advisible to enter upon a recital of cases as it would only prolong my remarks without any special benefit The pathognomonic symptoms of air and the fluid contents of the bowels passing through the opening is sufficient to establish the nature of the disease, but it sometimes requires a careful examination with the probe to discover the minute external opening, whether the sinus is direct, oblique or irregular, and a straight or long sinus existing.

Treatment.—Full and complete division of the whole sphincter ani, laterally, either by the use of the specula ani, or simply by the finger introduced, and dividing the sphincter from within outwards, which I much prefer. The sphincter ani is divided on the side (the left being the most frequent), where the external orifice is found. If the fistula is double, then divide the sphincter ani on both sides *laterally*. In all the cases operated upon the sphincter ani has closed up well and remained perfectly natural.

Previous to the operation, the bowels are to be moved freely by some cathartic the evening before—castor oil is the best, as it leaves the bowels less disposed to be moved afterwards. Before the operation, the bladder is to be emptied, either naturally or by the catheter. Chloroform can be administered as may be elected. After the operation, the case is treated the same as for fistula in ano, dressing with small portions of wet lint after the 3d day, every day, and allowing the wound to heal by granulation from the bottom. The bladder is evacuated every day by the catheter. The bowels may remain without being moved from two to three *weeks*, if necessary, 10 to 12 days being generally long enough. The patient taking one or two grains of opium two or three times a day, for a week or ten days. The fistula externally, either in the vagina or on the labia, is not *touched*,

either by caustics or *suture*. The same rule which guides the surgeon at the present day, as proposed by Brodie, Syme, Curling and Quain, where the internal opening in fistula in ano is high up, is not to disturb or touch it, but let it alone. Experience has taught that the internal opening in the case of fistula in ano, though two to three inches high up, will close, after the sphincter ani only is divided through to the external orifice, and so it is with recto vagina and labial fistula of the nature I refer to. Should, however, this not succeed, then a silver wire ligature, passed from an external opening, made where the sphincter ani is to be divided to, and the silver ligature passed up to the internal orifice, brought out and tied externally and tightened every day moderately, will allow the internal opening to close, and the fistula will be cured. Sometimes Mr. Luke of St Bartholomew adopts this course or method in fistula in ano. The principle as laid down by the surgeons above named, almost, if not all the surgeons at the present day, coincide in and adopt. It is this principle which my own experience verifies, in the cases of recto vagina (or recto labial) fistula I have referred to. In conversation with many surgeons of repute, and obstetricians, it is a singular fact, that they have not recognized the application of this simple procedure or operation for recto vaginal fistula—believing it is absolutely necessary that some operation is incumbent for the closure of the external orifice of the fistula, either by the actual cautery or by suture. A greater mistake never existed surgically, although the cases are *not* by any means unfrequent—my experience teaches me it seldom fails, except from the causes I have named—a cachetic or syphilitic constitution. I would here remark, that I have known the internal orifice to be closed in three to four days—the union however being very slight, but every day, in some cases it can be noticed, gradually becoming more and more firm and consolidated, until at length, in ten days or three weeks, the whole sinus or fistula is closed, and the patient cured. I beg to refer the members of the Society to the article of Dr. J. Rhea Barton, of Philadelphia, published in the American Journal of Medical Science, as far back as 1840, for the first record of the operation. Attracted by the simplicity (when I read the case) of the operation for so disgusting and annoying a complaint to the female, I resolved to adopt it the first opportunity that occurred, which was in 1844, and the second in 1854, and both cases proved successful. I have ever since continued to resort to the operation, with benefit to my patients, gratification to myself—and, I believe, with instruction to many medical gentlemen, and a large number of students at the hospitals. I have nothing original to claim. I only *claim* the credit of testing the truthfulness of the suggestion of my esteemed friend and preceptor, verifying its benefit, and take great pleasure, after so long an interval of time and extensive experience, to give publicity to it, not only in the operating theatre, but now present the claims of the operation to the members of the Society, for their consideration, for the welfare of the patient sufferer under this loathsome and disgusting affection.